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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Orthovisc injections high molecular weight right knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.
It is the opinion of the reviewer that medical necessity is not established for Orthovisc injections high molecular weight right knee.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
12/15/11 – Operative Report
02/21/12 – Clinical Note –MD
03/08/12 – Utilization Review Determination
04/24/12 – Appeal Letter –MD
04/30/12 – Utilization Review Determination

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female with a history of right knee pain. She had right knee arthroscopy with partial medial meniscectomy, chondroplasty of the inferior patella, and synovectomy of the suprapatellar bursa and medial and lateral gutter on 12/15/11. The claimant saw Dr. on 02/21/12. Physical exam revealed well-healed wounds without sign of infection or erythema. There was decreased range of motion of the right knee. There was decreased strength. There was tenderness over the iliotibial band proximally. The claimant was assessed with meniscal tear. The claimant was recommended for Orthovisc injections to the right knee. The request for Orthovisc injection was denied by utilization review on 03/08/12 due to lack of documentation of conservative care or imaging to support a diagnosis of osteoarthritis. An appeal letter by Dr. dated 04/24/12 states the operative report revealed grade 3 chondromalacia to the inferior pole of the patella. The claimant had continued pain to the anterior lateral knee, as well as the iliotibial band. Prior treatment included arthroscopy and

extensive physical therapy. The claimant was recommended for viscosupplementation. The request for Orthovisc injection was denied by utilization review on 04/30/12 due to lack of full conservative care, specifically cortisone injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant has continued right knee pain with loss of range of motion. The operative report did identify grade 3 patellofemoral chondromalacia. The clinical documentation did not contain any documentation regarding physical therapy to include physical therapy summary reports outlining the failure of conservative treatment. It is also unclear from the clinical records what medication regimen the claimant has been provided that failed to improve function or symptoms. The clinical documentation provided does not meet ODG recommendations for the requested service. It is the opinion of the reviewer that medical necessity is not established for Orthovisc injections high molecular weight right knee.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)